

3. Family Psychiatric History: (Learning disorders, mental retardation, ADHD, bipolar, depression, anxiety, schizophrenia, or drug/alcohol abuse)

Paternal (Father and his family) _____

Maternal: (Mother and her family) _____

4. Educational History: (Give current grade or grade child will be attending) _____

Current Grades: Please bring copy of current grades

_____ Elementary School
_____ Middle School
_____ High School

Special Education Classes: Y N If yes, what class?

Repeat a grade: Y N If yes, what grade? _____

Suspended: Y N What grade(s)? _____

Fight with teacher Use a weapon Skip School Steal

Cruel to other Children Member of a gang If checked, explain:

Extracurricular Activities: (Clubs, sorority/fraternity, band) _____

5. Employment History (Disability status for child/adolescent):

Has the child ever received disability benefits? Y N If so, when did they begin and why?

6. Legal History

Child/Adolescent: Youth Court Y N Training School Y N

DHS Y N If yes to above, explain: _____

History of: Stealing Y N Cruelty to Animals Y N

Setting Fires Y N If yes, explain: _____

Incarcerations-list family member (Ex. uncle-aggravated assault): _____

7. Developmental/Medical History:

Was the child full term pregnancy? _____

During mother's pregnancy, labor, or delivery, were there any problems? Y N

If yes, explain _____

Was the client's mother physically or emotionally abused? Y N If yes, explain _____

Any developmental delays? Any delays walking, talking, toileting? Y N If yes, explain _____

Major childhood illnesses, injuries, surgeries or seizures (include age) _____

History of: Bed wetting Y N Toileting Y N If yes, explain: _____

Immunization Status: (current) _____

Last eye exam: _____ Last hearing exam: _____ If problems, explain: _____

Date of Last Physical: _____ Pediatrician/Physician: _____

Current Medical/Physical Complaints: _____

Current Medications:

| Name of Medication | Dosage (amt. and frequency) | Purpose |
|--------------------|-----------------------------|---------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Medication compliance: Y N If no, explain _____

8. Nutritional Screening: (Consult Registered Dietician if 3 or more "Y" responses)

Special Diet Y N Overweight Y N Under Weight Y N
Poor Appetite Y N Unintentional Weight Loss/Gains Y N
Binge/Purge Y N

History of Eating Disorder: If yes, give age and treatments. _____

Significant Surgery & Date: _____

Head injury or Motor Vehicle Accidents: _____

History of physical/sexual/emotional abuse and/or neglect? List perpetrator, length of abuse, age of occurrence, and type _____

Family illnesses: (any history of the following illnesses?)

| | | | | |
|----------|---------------|----------|--------------|-------|
| Diabetes | Heart Disease | Seizures | Arthritis | Ulcer |
| Glaucoma | Tuberculosis | Thyroid | Hypertension | HIV |

If yes, indicate which family member: _____

If yes, indicate which family member: _____

9. Current Information and Daily Activities:

Appropriate hygiene and grooming: Y N If no, explain _____

If the client is 16 or older, does he/she drive and have a license? _____

Does client have responsibilities/chores? Y N Describe _____

Are they done when asked? Y N _____

What rewards/consequences are given? _____

What type of discipline is used in your home? _____

What type of discipline is used in your home? _____

When arguments surface, what are/were they about? _____

Describe client's relationship with parents/guardians and home environment: _____

How much time do you and your child spend together each week? _____

Describe client's relationships with friends and peers (school, home, and/or church): _____

What activities does client enjoy? _____

Is there a history of the following:

Nightmares Y N Tantrums Y N Suicide Y N

Fighting Y N Inappropriate Internet Use Y N Cutting Y N

Attempted Suicide Y N

Sexual Orientation _____ Is child sexually active? Y N If yes, date of onset and partner(s) _____

Describe your child's personal strengths _____

Describe your child's personal weaknesses _____

10. Psychiatric History:

Outpatient treatment or services: (give dates and reasons for treatment) _____

Psychiatrist/Psychologist/Therapist: _____

Medication history: (give medication names and ages when prescribed) _____

Inpatient treatment or services: (dates and reasons for treatment) _____

Psychological testing: (dates, reason for testing, and examiner) _____

11. Drug and Alcohol History:

Age of first **tobacco** use: _____ History of tobacco use: (frequency, duration(s), period(s) of abstinence) _____

Severity: Mild Moderate Severe

Age of first **alcohol** use: _____ History of alcohol use: (frequency, duration(s), period(s) of abstinence) _____

Severity: Mild Moderate Severe

Age of first **illegal drug** use/abuse: _____ History of illegal drug use: (frequency, duration(s), period(s) of abstinence) _____

Severity: Mild Moderate Severe

Current Drug/alcohol of choice: _____ Date of last use: _____

Quantity: _____ Frequency: _____

Drug/alcohol treatment: _____

***** STOP HERE. PLEASE READ NOTES TO PARENTS ON LAST PAGE.**

12. Mental Status

Appearance: Height _____ Weight _____ Posture/Gait _____

Hygiene/grooming _____

Behavior:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Calm | <input type="checkbox"/> Restless | <input type="checkbox"/> Fidgety | <input type="checkbox"/> Tremulous |
| <input type="checkbox"/> Motor Agitation | <input type="checkbox"/> Motor Retardation | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Uncooperative |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Poor Eye Contact | <input type="checkbox"/> Friendly/Cooperative | |

Speech:

- | | | | |
|-----------------|--|---|------------------------------------|
| Tone: | <input type="checkbox"/> Loud | <input type="checkbox"/> Normal | <input type="checkbox"/> Soft |
| Rate of Speech: | <input type="checkbox"/> Rapid | <input type="checkbox"/> Normal | <input type="checkbox"/> Pressured |
| | <input type="checkbox"/> Articulation deficits | <input type="checkbox"/> Slow | <input type="checkbox"/> Slurred |
| | <input type="checkbox"/> Mumbled | <input type="checkbox"/> Expressive or receptive deficits | |

Thought Processes:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Coherent | <input type="checkbox"/> Incoherent | <input type="checkbox"/> Flight of Idea | <input type="checkbox"/> Thought Blocking |
| <input type="checkbox"/> Paucity of Ideas | <input type="checkbox"/> Over-productive | <input type="checkbox"/> Goal Directed | |
| <input type="checkbox"/> Relevant | <input type="checkbox"/> Circumstantial | <input type="checkbox"/> Loosening of Associations | |
| <input type="checkbox"/> Flight of Ideas | <input type="checkbox"/> Evasive | <input type="checkbox"/> Tangential | |

Affect:

- | | | | | |
|-------------------------------------|--------------------------------------|-------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Restricted | <input type="checkbox"/> Flat | <input type="checkbox"/> Blunted | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Suspicious | <input type="checkbox"/> Grandiose | <input type="checkbox"/> Sad | <input type="checkbox"/> Elevated | <input type="checkbox"/> Labile |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Other _____ | | | |

Mood:

- | | | | |
|---------------------------------------|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Elation | <input type="checkbox"/> Euphoria | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Isolation | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Belligerence | <input type="checkbox"/> Incongruent | <input type="checkbox"/> Inappropriate | <input type="checkbox"/> Euthymic |

Cycles of Mood Instability: _____

History of manic behavior: _____

Panic symptoms: _____

Somatic:

- | | | | | |
|-------------------------------|-----------------------------------|---------------------------------|--|------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Eating | <input type="checkbox"/> Weight Change | <input type="checkbox"/> N/A |
|-------------------------------|-----------------------------------|---------------------------------|--|------------------------------|

Suicidal History: _____

Current Suicidal Ideation/Plan: _____

Thought Content:

| | | | | |
|---------------------|------------|-------------|-----------|-----|
| Delusions | Obsessions | Phobias | Suspicion | N/A |
| Ideas of Reference: | Religious | Persecutory | Grandiose | |

Hallucinations:

| | | | | |
|--------|----------|---------|-----------|-----|
| Visual | Auditory | Tactile | Olfactory | N/A |
|--------|----------|---------|-----------|-----|

Give onset, frequency, and content _____

Intellectual Level: Above Average Average Below Average

NOTES TO PARENTS

- **ALL PARENTS SHOULD MAKE OTHER ARRANGEMENTS FOR THE CLIENT'S SIBLINGS FOR EVERY APPOINTMENT. MS.RUSSELL WANTS TO HAVE UNINTERRUPTED TIME WITH THE CLIENT/PARENT AT EACH VISIT. THANK YOU SO MUCH FOR YOUR COOPERATION.**
- **APPOINTMENT TIMES WILL BE ROTATED, SOME AFTERNOON AND SOME MORNING APPOINTMENTS.**
- **PLAN TO ARRIVE 15 MIN EARLY FOR THE FIRST APPOINTMENT. THERE ARE A FEW MORE THINGS TO COMPLETE BEFORE THE APPOINTMENT BEGINS.**